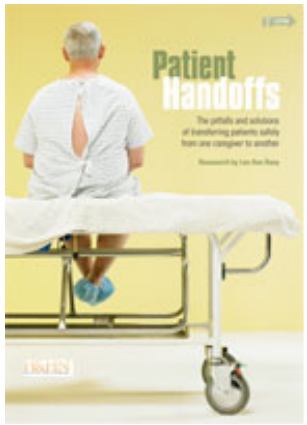
Patient Handoffs

By Lee Ann Runy

The pitfalls and solutions of transferring patients safely from one caregiver to another



As patients move from caregiver to caregiver and provider to provider, it's critical that information about their treatment goes with them. That doesn't always happen, though. The very nature of patient handoffs—be they within the hospital's four walls, or during a transfer to another department or facility—is prone to errors. Busy clinicians may omit important patient information during shift change, the lab may not have up-to-date vitals on a patient, or caregivers may not have a clear understanding of the patient's care plan and goals.

Indeed, communication breakdowns are a leading cause of medical errors. Between 1995 and 2004, communication problems were the primary cause of

65 percent of sentinel events, according to the Joint Commission. In 2005, a Joint Commission analysis found that 70 percent of sentinel events were caused by communication breakdowns, half of those occured during handoffs. To address the problem, the Joint Commission instituted a National Patient Safety Goal in 2006 calling on hospitals to implement a standardized approach to patient handoffs.

Finding solutions, however, isn't easy. There's a dearth of research regarding handoffs, says Richard Frankel, senior research scientist at the VA Health Services Research and Development Center of Excellence on Implementing Evidence-Based Practice at the Richard L. Roudebush VA Medical Center, Indianapolis. Many health care organizations are turning to the aviation and nuclear power industries for guidance. Salem (Ore.) Hospital, for example, adopted Crew Resource Management techniques originally developed by NASA and used throughout the airline industry. CRM instills standardization into all aspects of care delivery. "We had a number of events and near-misses in which communication was the root cause," says Laurie McKeown, M.D. Huddles are now standard during shift change, and forms and checklists help ensure the consistent transfer of information.

The key is to implement processes that clearly define the transfer of responsibility from one caregiver to another, standardize the communication process and allow for an interactive exchange between the parties involved. Frankel notes, "A lot of focus has been placed on the communication aspect and less focus on the relationship aspect of handoffs." To be effective, caregivers need to have a working relationship that is built on trust with the individuals involved in the transfer.

Health care organizations need to examine their current practices to identify barriers to the handoff process for transitions within and outside the hospital. For example, is the medication reconciliation process thorough? Are the discharge summaries timely? Has the hospital team spoken with the skilled nursing facility? "There's no one-size-fits-all process," says Cheri Lattimer, R.N., executive director of the Case Management Society of America. "The only common denominator is the patient." To improve handoffs, patients should be involved whenever possible because they can be strong advocates in the care process.

This gatefold examines patient handoffs and provides some tools and techniques hospitals are using to improve the process within their organizations.

What is a Handoff?

Handoffs occur anytime there is a transfer of responsibility for a patient from one caregiver to another. The goal of the handoff is to provide timely, accurate information about a patient's care plan, treatment, current condition and any recent or anticipated changes.

Tools and Techniques to Assist in Handoffs

Various tools and techniques can help streamline the handoff process and establish standardized communications. Organizations should consider using structured tools—such as mnemonics, templates or checklists—to ensure that information is not lost during the handoff. These techniques can also ensure the timely, accurate exchange of information. Below is a look at some common techniques. Hospitals may adopt or adapt these techniques as best fits their organization's culture and needs. These techniques can also be used in combination.

AUDIOTAPES

Audiotapes are a common means of sharing information during handoffs. They provide a fast, effective means of communication and can be bolstered by the use of a predetermined checklist. Audiotapes allow the outgoing clinician to provide a detailed assessment to the oncoming clinician. Used alone, audiotapes do not meet the Joint Commission National Patient Safety Goal. There needs to be an opportunity for those involved in the handoff to ask and answer questions. Ideally, the outgoing caregiver would remain on-site during review of the audiotape allowing face-to-face discussion.

FORMS and CHECKLISTS

Forms and checklists allow a quick, consistent exchange of information. Information technology systems, such as electronic medical records, can enhance the process. Forms and checklists can be placed in the patient record. Paper forms can be physically passed from one caregiver to another. When electronic forms are used, it's important to ensure that the information is received and reviewed. Again, it's important to allow caregivers to ask and respond to questions.

The FIVE-Ps
The Five-Ps were developed by Sentara Health Care in Norfolk, Va., to streamline the transfer of responsibility among caregivers and patient information.

The Five-Ps

Patient
Name, identifiers, age, sex, location

Plan
Patient diagnosis, treatment plan, next steps

Purpose
Provide a rationale for the care plan

Problems
Explain what's different or unusual about this specific patient

Precautions
Explain what's expected to be different or usual about the patient

Sources: *H&HN* research and Sentara Health Care, 2008

I PASS the BATON

This technique is recommended by the Department of Defense's Patient Safety Program to provide an optimal structure to improve communication during transitions in care. It should include opportunities to confirm receipt, ask questions, clarify information and verify that the information is understood. This technique is designed to assist with both simple and complex handoffs.

I	Introduction	Individuals involved in the handoff identify themselves, their roles and jobs
P	Patient	Name, identifiers, age, sex, location
A	Assessment	Present chief complaint, vital signs, symptoms and diagnosis
S	Situation	Current status and circumstances, including code status, level of certainty or uncertainty, recent changes and response to treatment
S	Safety Concerns	Critical lab values and reports, socioeconomic factors, allergies and alerts, such as risk for falls
the		
B	Background	Comorbidities, previous episodes, current medications and family history
A	Actions	Detail what actions were taken or are required and provide a brief rationale for those actions

T	Timing	Level of urgency and explicit timing, prioritization of actions
O	Ownership	Who is responsible (nurse/doctor/team), including patient and family responsibilities?
N	Next	What will happen next? Any anticipated changes? What is the plan? Any contingency plans?

Source: Department of Defense Patient Safety Program, "Healthcare Communications Toolkit to Improve Transitions in Care," 2008

SBAR + 2: An adaptation to the popular technique

SBAR is a communications technique that is modeled after a process used on nuclear submarines. It facilitates the consistent, concise exchange of information. Hospitals are adopting SBAR to improve communication exchanges among clinicians. It is also being adopted to standardize the exchange of information during the handoff process. SBAR is suitable for simple handoffs; some industry experts feel SBAR does not delve deeply enough into the level of information needed during a complex handoff. "SBAR is a good model, but it's incomplete," says Steve Harden, president of LifeWings Partners, Memphis, a health care consulting firm that specializes in adapting the Crew Resource Management technique to the health care setting. "Organizations need to be specific about what each letter means." He suggests adding two letters to the mnemonic to make the communication exchange more thorough.

I	Introduction	Individuals involved in the handoff identify themselves, their roles and jobs
S	Situation	Complaint, diagnosis, treatment plan and patient's wants and needs
B	Background	Vital signs, mental and code status, list of medications and lab results
A	Assessment	Current provider's assessment of the situation
R	Recommendation	Identify pending lab results and what needs to be done over the next few hours and other recommendations for care
Q	Question and Answer	An opportunity for questions and answers is built into the handoff process

Source: *H&HN* research, 2008

Joint Commission Requirements

The 2006 Joint Commission National Patient Safety Goals included a requirement that hospitals implement a standardized approach to handoff communications, including an opportunity for individuals involved in the process to ask and respond to questions. The goal does not dictate how organizations should do this; each organization must develop its own method.

The goal is meant to be flexible, recognizing there's a need for variation within organizations. For example, the type of information vital to patient handoff from the OR to PACU differs from the type of information needed for transfer from the ED to a cath lab. And the handoff during nursing shift change would likely differ from the handoff of a patient from one physician to another.

To meet the Joint Commission requirement, organizations must define, communicate to staff and implement a process that results in the consistent communication of patient information. According to the Joint Commission, standardization provides an opportunity to educate staff about the process and helps support the consistent implementation and use across the organization. Again, the process may vary slightly from department

to department, but the basic premise is the same. It's important to include a step to review the effectiveness of the processes once they are in place and address any problems that are identified.

The Joint Commission provides details as to what a standardized approach should include:

- The handoff situation
- Who is, or should be, involved in the handoff communication
- Opportunities for individuals involved in handoffs to ask and respond to questions
- An outline for when to use certain communication techniques, such as repeat-back or read-back or the Situation-Background-Assessment-Recommendation (SBAR) technique
- What print or electronic information should be available during the handoff

Source: The Joint Commission, 2008

The U.S Department of Defense Handoff Model

The triangle is designed to help providers understand where communication gaps occur. Not all of the data elements apply to all types of handoffs; the triangle represents the elements required for a complex patient handoff.

Urgency	Emergency Treatment	Questions to Ask
MAJOR CONSID	SAFETY CONCERNS	• Identify safety concerns (e.g., mental confusion, allergic reactions, fall risk, and specific error risk based on circumstances, site or procedure verification)
	TIME CRITICAL ACTIONS	• Identify time critical actions (e.g., give IV antibiotics within 4 hours, to operating room within 4-6 hours, and IV medications needed STAT.)
	ANTICIPATION: NEXT STEPS	• What comes next and what is expected? What potential changes to watch for? What are the next steps (e.g., surgery, biopsy, chemotherapy)?
	WHO IS RESPONSIBLE?	• Identify who is responsible for the patient's care. Establish who to call for appropriate information. Who is the primary care provider? What are the patient and family responsibilities?

E R A T I O N S	PATIENT/FAMILY AWARENESS	• Is the patient and family aware of information needed for informed decision-making? Are they aware of the care plan and available to participate in the plan? Do they understand all of the responsibilities for monitoring an ongoing care plan?
	MEDICATION RECONCILIATION	• Accurate and updated information including lists and doses is avialable to the patient and care providers. This is the opportunity for a comprehensive medication review and to make corrections or clarifications as needed.
	GENERAL CARE PLAN	• The general care plan is established and all related protocols and critical pathways determined. State it briefly but concisely. If needed, develop a disease management plan.
E V A L U A T E	CIRCUMSTANCES/STATUS	• Establish the patient's current circumstances. What is the patient's status and medical condition? What is their resuscitation-code status?
	UNCERTAINTIES	• What is the level of confidence about current condition and remaining uncertainties? What information is still pending, such as lab or imaging results? What consultations are still pending? Clarify "what we don't know yet."
	CRITICAL VALUES & INFO	• Establish critical values or information (e.g., serum potassium of 2.4), critical clotting study results, recent imaging or biopsy results suggesting or confirming the presence of a major disease (e.g., cancer or active pulmonary tuberculosis).

	MAJOR RISKS & PITFALLS	• Are there any known risks, pitfalls, known or frequent complications with the patient (e.g., risk of fall, thromboembolism, arrhythmia, suicide risk, pressure injury)?
BACKGROUND	ADMINISTRATIVE DATA	• Verify the patient's insurance. Who's the attending physician and treatment team? Is the family available for support? Are there any advance directives?
	PATIENT INFORMATION	• Full name, identification numbers, age, sex, location
	BACKGROUND MEDICAL DATA	• Is there any pertinent medical history with the patient? Have there been any recent changes in their condition or circumstances? Any previous episodes of the illness?
	RELEVANT DIAGNOSIS	• What is the revelant diagnosis to the transition of care?

Source: Department of Defense Patient Safety Program, "Healthcare Communications Toolkit to Improve Transitions in Care," 2008

Case Studies

1. Improving Handoffs in the ED, Methodist Hospital, Indianapolis
The fast-paced environment of the emergency department, along with high patient turnover, makes patient handoffs a challenge. At Methodist Hospital, ED shift reports primarily took place at the automated tracking board in the nurses' station. Outgoing nurses gave verbal updates to the oncoming shift. When charged with developing a standardized handoff approach, the ED initially instituted a written handoff report. But nurses said the process was burdensome because of the high turnover and the additional paperwork. The organization then developed a bedside handoff process. Despite some initial resistance, the process has helped boost nurse and patient satisfaction. The outgoing and oncoming nurses round beds together and exchange vital patient information. "Nurses were afraid to have the discussion in front of the patient," says Debra Fabert, R.N., ED clinical manager. After three months, however, the nurses gave the program high marks. "All it takes is one near-miss being caught and they are sold," Fabert says. The process helps nurses prioritize care and promotes accountability between shifts. Patients feel included and are reassured that the nursing staff is aware of their situation. Scripting was built into the process to help nurses during uncomfortable situations, such as the presence of family or friends and frequent interruptions from the patient. Fabert says it's important to continually evaluate the process to ensure ongoing nurse and patient satisfaction.

2. The EMR and PACU Handoffs, The Methodist Hospital, Houston
Methodist Hospital adopted the SBAR (Situation-Background-Assessment-Recommendation) methodology to assist in the patient handoff process. The post-anesthesia care unit had some unique handoff challenges to address, including numerous detailed reports that had to be produced for every patient. The PACU worked with the IT department to develop an electronic solution. The new process extracts patient information from the PACU electronic

medical record using SBAR methodology and sends that information directly to the receiving unit's printer. The nurse or unit clerk calls to verify receipt and ask whether there are any questions. Prior to this process, the exchange of patient information was conducted primarily via the phone. Nurses spent a good deal of their time on hold trying to contact each other. "Now nurses can spend more time at the patient bedside," says Janet Gilmore, R. N., perioperative services.

3. I PASS the BATON and SBAR, Trinity Medical Center–West, Rock Island, Ill.
When looking to standardize the handoff process throughout the organization, Trinity Medical Center combined two communications techniques: SBAR and I PASS the BATON. SBAR was already used in the organization to enhance communications between nurses and physicians. To facilitate handoffs, nurses now keep brief, up-to-date forms on patients using the SBAR format. These forms, which are not part of the patient's medical record, are copied and placed in a plastic baton and transported along with the patient. "We needed a means to get critical information to the support areas," says Brenda Poole, R.N., senior director of patient care operations. For example, before use of the forms when patients were transported to radiology, clinicians would have to review the entire medical record to find the information they needed. The forms save time because they provide quick access to important information. The forms include a place for specialty areas to add information and a contact number for the outgoing caregiver, and must be signed by both the sending and receiving caregivers.

Types of Handoffs

The definition of "handoff" is purposefully broad to encompass the wide array of handoffs that occur across the health care setting.

In hospitals, types of handoffs include:
• Nurse shift changes
• Physicians transferring responsibility for a patient
• Physicians transferring on-call responsibility
• Temporary relief of coverage (to allow for breaks during shifts, for example)
• Anesthesiologist report to post-anesthesia recovery room nurse
• Nursing and physician handoff from the emergency department to an inpatient unit

Handoffs also refer to the transfer of patient responsibility across the health care continuum.
Examples include:
• Primary care physician to hospital admissions department
• Patient transfer from one hospital to another
• Patient transfer to a skilled nursing facility
• The relay of laboratory and radiology reports to the primary care physician after discharge
• The provision of patient information to a home health care agency
• Educating the patient and family upon discharge to home
• Discharge summary information from hospital to primary care provider

Sources: The Association of periOperative Registered Nurses and the Joint Commission, 2008

10 Barriers to effective handoffs

1. Lack of education at nursing and medical schools
2. Health care system that historically has supported individual autonomy and performance
3. Lack of engagement of patients and families in the care process
4. Resistance of change among staff
5. Lack of time for providers to devote to handoffs

6. Problems in the physical setting, including background noise and interruptions
7. Language barriers between clinicians and between the clinician and the patient It's also important for clinicians to avoid abbreviations and ambiguous terminology
8. Failures in mode of communication, such as fax machine or e-mail or the inability to locate the patient record
9. Lack of definitive scientific research and data to identify accepted handoff best practices
10. Lack of financial resources to implement standardized handoff processes

10 Tips for effective handoffs

1. Allow for face-to-face handoffs whenever possible
2. Ensure two-way communication during the handoff process
3. Allow as much time as necessary for handoffs
4. Use both verbal and written means of communication
5. Conduct handoffs at the patient bedside whenever possible. Involve patients and families in the handoff process. Provide clear information at discharge
6. Involve staff in the development of handoff standards
7. Incorporate communication techniques, such as SBAR, in the handoff process Require a verification process to ensure that information is both received and understood
8. In addition to information exchange, handoffs should clearly outline the transfer of patient responsibility from one provider to another
9. Use available technology, such as the electronic medical record, to streamline the exchange of timely, accurate information
10. Monitor use and effectiveness of the handoff. Seek feedback from staff

Source: *H&HN* research, 2008

Resources

- Association of periOperative Registered Nurses, "Perioperative Patient 'Hand-Off' Tool Kit,"www.aorn.org/PracticeResources/ToolKits/PatientHandOffToolKit
- The Care Transitions Program, www.caretransitions.org
- Department of Defense Patient Safety Program, "Healthcare Communications Toolkit to Improve Transitions in Care,"http://dodpatientsafety.usuhs.mil
- The Joint Commission, "Improving Handoff Communication,"www.jcipatientsafety.org/15427
- The Institute for Healthcare Improvement, www.ihi.org
- The National Transitions of Care Coalition, www.ntocc.org. The NTOCC is scheduled to release a toolkit in May that will help health care providers address problems in transitioning patients from one level of care to another.

How We Did It: This gatefold was produced by researching published studies and articles and conducting interviews with hospital and industry executives.

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